by transplanting a small piece from the other eyelid, so as to preserve the natural delicacy of the skin of the parts.

Mr. **Gant** agreed that the similarity of texture on both sides of the body was worth recollecting in these cases.

Mr. **Spencer Watson** gave brief particulars of cases that had come under his notice at the Great Northern Hospital, and considered that the success of the operation depended very much in keeping the transplanted pieces in position.

Mr. **Henry Arnott** spoke of a case in which two ulcers existed, one having been treated by transplantation and the other left alone; both closed pretty much at the same time; and, in reply to Mr. Heath, said that the case was one of keloid, following a burn.

Mr. **Reeves** thought that the large pieces of skin should be transplanted.

Mr. **Arthur Durham** eulogized Mr. Pollock and the operation, and said that in a case of pigmentary nævus that had come under his care it was positively beautiful to see the islands of skin joining the mainland and the processes of repair proceeding so rapidly.

Mr. **Callender** quoted cases under the care of Mr. Pick and Mr. Willet, all of which had done well; and in reply to a question from Mr. Heath, said in all the cases cited, the ulcer was, as far as he knew, of the usual tertiary syphilitic form.

Mr. **Pollock** closed a long discussion by briefly explaining his own views as to the physiological aspect of the question, and as to the success of the operation in syphilis, and regretted that the state of Paris had prevented any recent intercommunication with Dr. Reverdin, the talented author of the operation. According to his own experience, and particularly with rupial sores, small pieces of skin answered as well as large; and, in this matter, some consideration should be shown to the patient.—*Lancet*, Nov. 19, 1870.

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56. *New Instrument for securing the Pedicle in the Operation of Ovariotomy.*—Dr. **Graily Hewitt**, adopting the conclusion that the best method of treating the pedicle in ovariotomy is to bring it to the surface of the wound, suggests a new method of securing it in that position. A framework of steel, shaped somewhat like a shoe-buckle, measuring two inches and a half by one inch and three-quarters, the steel band being two-eighths of an inch wide and one-eighth of an inch thick, is provided with studs, eight in number, fixed on the framework. The studs project three-eighths of an inch. The pedicle is to be tied in two or three segments, according to its size, by double twine ligatures, and the ends fixed to the studs of the framework, the ligatures acting much as the tongue of a buckle. Thus the pedicle can be easily maintained at the surface of the wound, easily treated, and the healing materially expedited. —*British Med. Journal*, Oct. 1, 1870.

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57. *Ovariotomy in a Girl aged Twelve.*—M. **Jouon**, professor in the medical school of Nantes, successfully performed this operation a short time ago. The patient had been suffering from an abdominal tumour for the last eighteen months, and the growth had reached the size of a twin pregnancy at the end of gestation. The diagnosis was not easy, and at one time hydatid of the liver was suspected. On the strength of the last supposition it was determined to open the abdomen by caustics. When the slough had been incised, it was found, after the evacuation of some liquid, that the abdomen contained a capacious pouch, studded with fibrous tumours projecting in its cavity. As now the diagnosis was clear, and the girl lost ground every day, ovariotomy was performed. The cyst was multilocular, and the adhesions numerous; but, in spite of these difficulties, and the patient's tender age, she was well on the forty-sixth day after the operation.—*Edin. Med. Journal*, November, 1870.

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58. *Solvents for Ear Wax.*—The *Revue de Thérapeutique*, June 15th, 1870, contains an account of some experiments instituted by Dr. J. E. **Petrequin**, Ex-Surgeon-in-Chief of the Hôtel-Dieu of Lyons, to ascertain the best solvent for ear wax. Inspissated wax is well known to be a common cause of deafness,

and it is very desirable to determine the most efficacious and least painful means of removing it. Dr. P. tried successively almond oil, a mixture of glycerine and oil, pure glycerine, alcohol, a mixture of olive oil and essence of turpentine, alkaline solutions of white and also of green soap in water, pure turpentine, chloroform, and sulphate of carbon. He found some to have no solvent properties, and others too irritating. The best solvent, he states, is tepid water, which acts equally on soft and indurated cerumen. The hard cerumen under the action of water swells, has a tendency to disintegrate, and is very easily broken up.

OPHTHALMOLOGY.

59. *Does Disease of the Cerebellum lead to Loss of Sight?*—The difference betwixt a tumour and softening from embolism, with regard to the production of certain secondary symptoms, is very great. So far as Dr. HUGHLINGS JACKSON has observed, double optic neuritis never occurs along with softening from embolism of the middle cerebral artery, but it nearly always occurs with tumours—they are usually syphilitic—in the region which this vessel supplies. It is one of the results of a local encephalitis. It is sometimes discussed whether disease of the cerebellum produces loss of sight or not. The evidence is that it sometimes does and sometimes does not. The word "disease" is vaguely used. Softening rarely if ever does—tumour nearly always does. (Cases of tumour so placed, or so large, as to lead to pressure on the corpora quadrigemina, are excluded from consideration.) In more general terms, *destruction* of the cerebellum does not, but irritation (encephalitis about a foreign body, or irritation propagated in vaso-motor regions?) does. Then the word "produce" is used vaguely also. The existence of blindness along with disease of the cerebellum is no proof that the disease has destroyed any "centre for sight." The blindness depends on inflammation of the optic nerves. This is not a mere verbal refinement. It is quite certain that there may be very abnormal ophthalmoscopical appearances when the patient can read the smallest type, and when he considers his sight to be quite good. Moreover, blindness may not follow such inflammation. The nerve-fibres of the optic nerve-bundle are not in *fault;* they *suffer* from the faults of the other ingredients of the bundle. The inflammation, Dr. Hughlings Jackson believes, is brought about by frequent and irregular contractions of the arteries supplying the nerve-trunks, the contractions being the result of discharges of unstable gray matter in the part of the brain diseased. (Sudden *attacks* of temporary loss, or of great defect, of sight are not very uncommon in the onset and course of cases of optic neuritis in physician's practice.) In considering the manner of production of changes of nutrition through the intermediation of vaso-motor nerves, we have not to think merely of persistent contraction of arteries as the result of a continued irritation of the vaso-motor nerves, nor merely of permanent dilatation, the result of palsy of these nerves. For nervous discharges—of gray matter, at least—are intermittent; and if, in cases of tumour, much gray matter be involved in the local and secondary encephalitis, there will be not only excessive but many repeated discharges. Thus orderly rhythmical nutrition of the nerves will be impossible. With regard to the position of disease producing optic neuritis (and other symptoms of its class, *i.e.*, secondary symptoms, the results of a local encephalitis), the question whether white or gray matter is involved is of more importance than the question whether the cerebrum or the cerebellum be the seat of disease. Admitting, as is most probable, that the optic nerves have connections—probably very indirect connections—with the cerebellum, as they have with the cerebrum, it is still maintainable that destruction of great part of one lobe of the cerebrum or of the cerebellum produces no defect of sight. But nervous organs are connected not only by nerve fibres, but also by arteries (indirectly by vaso-motor nerves). Hence, whilst *destruction* of no part of the cerebrum or cerebellum leads to